



Moore, D. A., Russell, A. E., Arnell, S., & Ford, T. J. (2017). Educators' experiences of managing students with ADHD: a qualitative study. *Child: Care, Health and Development*, 43(4), 489-498.
<https://doi.org/10.1111/cch.12448>

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Educators' experiences of managing students with ADHD: A qualitative study

Darren A Moore^{*1}, Abigail Emma Russell¹, Sophie Arnell², Tamsin J Ford¹

¹ University of Exeter Medical School, South Cloisters, St Lukes, Exeter, Devon, EX1 2LU, UK

² University of Exeter College of Life and Environmental Sciences, Psychology, Washington Singer Building, Perry Road, Exeter EX4 4QG, UK

*Corresponding author: Darren A Moore, University of Exeter Medical School, South Cloisters, St Lukes, Exeter, Devon, EX1 2LU, UK (e-mail: d.moore@exeter.ac.uk).

Acknowledgements

Preparation of this manuscript was supported in part by NIHR Collaboration for Leadership in Applied Health Research and Care South West Peninsula (PenCLAHRC). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR, NHS or Department of Health.

We would like to thank Marianne Tay for her help with data collection and coding.

Accepted version of

Moore, D. A., Russell, A. E., Arnell, S., and Ford, T. J. (2017) Educators' experiences of managing students with ADHD: a qualitative study. *Child: Care, Health and Development*, 43: 489–498. doi: [10.1111/cch.12448](https://doi.org/10.1111/cch.12448).

Abstract

Background: The symptoms of attention-deficit/hyperactivity disorder are associated with difficulty coping with the social, behavioural and academic components of school. Compared to medication and other non-pharmacological treatment, there is less evidence relating to school-based interventions to support children with ADHD. There is additionally an absence of any research focused on the experiences and practices of educators in the UK around how they work with children who are inattentive, impulsive and hyperactive.

Methods: Forty-two educational practitioners from primary, secondary and alternate provision schools in the UK participated in focus groups or individual interviews that explored (1) their experiences of managing students with ADHD in the classroom and (2) factors that helped and hindered them in this endeavour. Transcripts were analysed using thematic analysis.

Results: Analysis identified six themes: Broad strategies; student-centred; inclusive strategies; labelling; medication; and relationships. Participants' experiences of managing students with ADHD drew upon a wide range of strategies that typically involved responding to individual needs in an inclusive manner, so individuals with ADHD could access the classroom with their peers. Participants spoke about three factors that helped and hindered managing students with ADHD. Labelling of students with ADHD was reported, with the negative aspects of labelling, such as stigmatisation, affecting the classroom. Educators reported mixed experiences regarding the helpfulness of medication; where helpful it allowed the use of strategies in the classroom. Although students with ADHD were described as having rollercoaster relationships, positive relationships were considered key to the support of children with these difficulties.

Conclusions: This study suggests that factors such as attitudes towards ADHD, relationships experienced by students with ADHD and other treatments being delivered need to be carefully considered before strategies are put in place in the classroom. This study supports the need for further work on the implementation of evidence-based school interventions for ADHD.

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Attention-deficit hyperactivity disorder (ADHD) is a developmental disorder characterised by developmentally inappropriate and pervasive levels of hyperactivity, inattention and impulsivity (APA 2013). The core symptoms of ADHD may affect a child's functioning in an educational environment and a diagnosis of ADHD is associated with poor school outcomes including poorer reading ability (Rabiner et al. 2000), writing and mathematics (Rodriguez et al. 2007), lower school grades (Loe & Feldman, 2007) and exclusion from school (Parker et al., 2015). Childhood hyperactivity has been shown to predict adolescent behavioural and academic problems, and may reduce the number of qualifications obtained (McGee et al. 2002). The school system, therefore, plays an important role in addressing the academic impairment of children with ADHD (Daley & Birchwood 2010). Indeed, the UK's National Institute for Health and Care Excellence (NICE) clinical practice guidelines recommend that only teachers who have received training about ADHD and its management should provide behavioural interventions in the classroom to help children and young people with ADHD (NCCMH 2009). However, teacher training specific to ADHD behavioural interventions is often considered to be lacking (West et al. 2005).

Effective intervention to support children with ADHD involves both medication and non-pharmacological treatments. There is a relatively small evidence base relating to school-based treatments for ADHD compared to that for medication or non-pharmacological treatments like parent training. Reviews focused on interventions delivered in the school setting have reported beneficial effects of a variety of non-pharmacological interventions, including 'academic', 'contingency management' and 'cognitive behavioural' interventions (DuPaul et al. 2012), 'behaviour modification techniques' (Miranda et al. 2006), 'peer tutoring', 'self-regulation' (Trout et al. 2007) and 'self-monitoring' (Reid et al. 2005) for both academic and behavioural outcomes. However, a more recent review reported some beneficial effects of non-pharmacological interventions for ADHD used in school settings, but noted that it was unclear which aspects of

intervention packages are most effective for which students and in what contexts (Richardson et al., 2015).

This previous literature has focused on quantitative evidence relating to school-based interventions. Qualitative research regarding the non-pharmacological treatment of ADHD is scarce. One 2016 systematic review synthesised views from young people with ADHD, their parents and educators about the experiences of and attitudes towards non-pharmacological interventions delivered in the school setting (Moore et al., 2016a). The findings of this review highlighted the importance and complexity of the school context, which is essential to explore in order to understand what works and for whom. The same review revealed a gap in the literature for qualitative research focused on the experience of teachers in the UK as the majority of qualitative studies previously conducted had examined the experience of teachers in the USA, who are working in a different educational system. A gap was also identified for the views of educators other than teachers. The culture of inclusivity and key role that mainstream teachers play in provision for special educational needs students (Kennedy, 2015), means it is important to consider how UK educators respond to ADHD in the classroom and what helps or hinders their management of these students.

The current study therefore aims to use qualitative research methods to explore UK educators' experiences of managing ADHD in school. By using the term "educators" we explicitly set out to recruit the full range of practitioners who are involved in teaching and learning for children with ADHD in the school setting, not just their teachers. There were two specific research questions:

1. How do educators respond to ADHD in the classroom?
2. What are the barriers and facilitators to these responses?

Method

Participants

Forty-two school practitioners that self-identified as having worked with children or young people with ADHD participated. Participants worked in nine schools in the South West of the UK who responded to either a direct email from a researcher or through a newsletter (223 schools approached). If a school expressed interest in participating, a named contact, often the head teacher or special educational needs coordinator (SENCo), acted as gate-keeper and liaised with the researcher in identifying staff with relevant experience who were interested in participating. Table 1 details participant characteristics. Educators worked in primary schools (ages 4-11), secondary schools (ages 11-18), or pupil referral units (PRU; alternative provision, for students excluded from mainstream education). Practitioners held a wide range of roles and experience.

Table 1: Characteristics of participants

Characteristic	N
Female	32
Primary	19
Secondary	7
PRU ¹	16
Worked with ages 0-4	14
Worked with ages 5-11	33
Worked with ages 11 and up	25
Worked with <10 children with ADHD diagnosis	13
Worked with ≥10 children with ADHD diagnosis	12
Teacher	16
Teaching assistant	11
Coordinator or team leader or head of year	11
Pastoral support	3
SENCo ²	6
Head/deputy head teacher	5

Notes: n=42; numbers may not tally as some practitioners had multiple roles within the school and some had worked with a large range of age groups. 1. Pupil Referral Unit. 2 Special Educational Needs Coordinator.

Data collection

Participants took part in either a focus group (n=39) or individual interview (n=3). We used focus groups where there was more than one participant from a school, otherwise individual interviews were conducted in order to capture the range of attitudes, beliefs and experiences across as many possible individuals and schools. Focus groups had between two and 12 participants. Interviews and focus groups took place at the school where the practitioners worked, a nearby school or in one case the local University campus. The use of focus groups rather than individual interviews where numbers permitted was convenient for busy participants with little time, the use of focus groups in combination with individual interviews in qualitative research is well established (Morgan, 1996). Focus groups allow breadth of experience and views around a topic to be elicited as well as exploring similarities and differences in participant views. Interviews can explore individual's understandings in greater depth, thus the two techniques together allow for a rich understanding of both individual experiences and beliefs and how these are understood and expressed in the wider social context of the school (Bauer et al., 2004; Michell, 1999). Interviews and focus groups were semi-structured allowing for consistency in topics covered as well as scope to probe further in response to participants' views and adapt the topic guide in light of interesting findings from previous interviews. The University of Exeter Medical School research and ethics committee provided ethical approval for this study. Pseudonyms are used throughout.

Procedure

All focus groups and interviews were conducted by the second author (AR). In focus groups she was assisted by either the third author (SA) or another research student who took field notes (MT). Participants provided informed consent before taking part and were given the opportunity to choose a pseudonym to be used for the study analysis and write-up. Each interview or focus group was recorded using a Dictaphone and lasted between 40 minutes and one hour, the length was determined by the amount of time participants had available. Both interviews and focus groups

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followed the same topic guide (available on request from contact author) which covered experiences working with children with ADHD including how they managed these students in the classroom. At the end of each focus group or interview, practitioners were given an explicit opportunity to add to or raise any other issues they wished to discuss. Incentives were not provided with the exception of light refreshments during the session.

Analysis

Audio recordings were transcribed verbatim by the two research students and transcriptions were checked by AR prior to data analysis. Transcripts were then read and re-read by DM and AR. Data were analysed using thematic analysis as outlined by Braun and Clarke (2006). Thematic analysis is a flexible method for analysing qualitative data used to identify, analyse and organise repeating patterns within data. Analysis commences by coding features of the data according to meaning, then organising these codes into patterns of shared meaning, known as themes (Braun & Clarke, 2006). AR and one of the two research students independently coded each transcript. Coding each transcript twice increased the reliability of the analysis. This coding was amalgamated using NVivo version 10 with similar codes being merged. The coded data were grouped into tentative themes and subthemes by AR and DM. These were reviewed to ensure that relevant extracts fitted under each theme and whether themes appeared across the data set. This process continued in an iterative manner until a thematic map was drafted. Themes were clearly defined in order to identify and describe their core aspects. Although this process is described linearly, in actuality analysis was cyclical and reflexive (Braun & Clarke, 2006).

Results

Analysis identified six themes that captured participants' views regarding their experience of managing children who have ADHD in the classroom and factors that helped and hindered this. Themes and how they relate to research questions are shown in Table 2.

Table 2: Research questions, themes and key issues

Research Question	Theme	Key issues
How do educators respond to ADHD in the classroom?	Broad strategies	Practitioners report using many different strategies that do not exclusively target the core symptoms of ADHD. Strategies tend to be ad hoc rather than recognised interventions for ADHD: “They all have like personalised timetables to try and meet their needs, not just the ADHD ones” (Jane, SENCo, PRU).
	Student-centred	Strategies used are student-centred, making individual adaptations so that the child can access the classroom: “I draw up a pupil passport with a picture, what the child likes, so it’s a very pupil-centred process, and then what tends to happen is like Paul says we make lots of modification and adaptations to the classroom” (Rose, Team Leader for Learning Support, Secondary)
	Inclusive strategies	The strategies used are inclusive rather than involving withdrawal from mainstream teaching, which was seen as something to be avoided: “My role is to try to keep the child in the lesson” (Hannah, Teaching Assistant, Secondary).
What are the barriers and facilitators?	Labelling	Practitioners recognise the process of labelling occurring for children with ADHD. While the label may aid understanding and access to support, the negative aspects of labelling “can sometimes just compound them into their difficulties, rather than pull them out” (Ryan, Pastoral Leader, Primary)
	Medication	Practitioners see positive impacts of medication that can then allow the use of strategies. “if he hadn’t had his medication he was all over the place” (Sally, Teaching Assistant, Primary). However, issues include adverse effects and medication (or lack of) used as an excuse for behaviour.
	Relationships	Practitioners see the relationships children with ADHD hold as key to their success in school: “the relationship is key, really important” (Rebecca, Family Support Manager, PRU) A good relationship can unlock the potential of children with ADHD and therefore social skills and relationships are targeted in the classroom: “we got him back into school and a lot of that was about building relations between the child and the teachers” (Jemima, Teacher, PRU)

Broad strategies

When asked about their experience of managing ADHD behaviours in the classroom during interviews and focus groups, participants listed a wide range of strategies that they employed successfully with students with ADHD. It was clear that participants considered flexible use of a wide range of support to be helpful for students with ADHD as opposed to a one size fits all response. Many strategies practitioners mentioned were preventative, aiming to avoid behavioural issues:

We issue them with an exit card ... so they'll be allowed to leave the lesson, come to somewhere safe like the student support centre, just a bit of calm down time and then go back (Laura, Teaching Assistant, Secondary).

It was also of interest that the strategies practitioners reported using with students rarely target the core symptoms of ADHD (hyperactivity, inattention and impulsivity). Practitioners far more often aimed to encourage appropriate classroom behaviour, increase study skills and help these students to work with their peers. Many of the strategies that practitioners reported using are therefore focused on skills that might be under-developed in children with ADHD. Skills that practitioners specifically mentioned range from academic to emotional, social and self-regulation skills:

Laura: we use the NFER Nelson Emotional Literacy assessments and from that I can take where one of their skills, emotion or literacy skills, it could be motivation, it could be social skills, that we need to work on. We use also use the Boxhall profile so we can see different developmental strands and we can start with that so we can work on where we feel their weaknesses are and try and build on their strengths ... (Teaching Assistant, Secondary)

It is clear that strategies mentioned were sometimes used for other children in the class, not just those with ADHD:

The year eight [class], we try to do lots of interactive learning and again they love all that sort of stuff, all of them do (Janet, Teacher, Secondary).

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A strategy that appeared to be more targeted at improving difficulties related to ADHD in particular was using physical activity. Teachers described using “movement breaks” (Rose, Team Leader for Learning Support, Secondary) and “lots of little things where they can get up” (Jane, Teacher, Secondary). This is mirrored in other literature where giving motion and movement is seen to be beneficial with children who are hyperactive (Langberg et al. 2011).

The one strategy that practitioners noted does not always work with students with ADHD was rewards. While some participants used “any opportunity to reward or praise him” (Louise, Subject Coordinator, PRU), others noted that rewards met resistance due to students’ previous experiences. Some participants suggest it is “to do with the way that rewards are being used at home” (Louise, Subject Coordinator, PRU) where either rewards are not forthcoming: “so why would he want to earn it [at school]” (Monica, Teacher, PRU) or that children “think of rewards as blackmail” (Steve, Teaching Assistant, PRU).

Student-centred

While the breadth of strategies and the perceived effectiveness of the majority of these strategies were striking, as was the focus of these strategies upon the individual student. One example, mentioned in the quote below is a pupil passport, which documents a student’s key strengths, needs and the strategies and key adjustments to teaching and learning required:

*Once I’ve had the information from the paediatrician, I would put them on the [SEN] code of practice and I would draw up a passport with those recommendations
(Rose, Team Leader for Learning Support, Secondary).*

The strategies that participants described aim to help children with ADHD access the classroom and academic work. The following quote indicates that these student-centred strategies need to be flexible:

And really the key things are always are they learning? So I’d constantly be testing that, to make sure that they were learning. If they weren’t, then you’d have to change it and do whatever you can (Jemima, Teacher, PRU).

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Indeed, practitioners mentioned that they used the personal interests of their students with ADHD as a means to engage them in classwork:

He was really good at kind of extreme sports and stuff so I kinda did a whole literacy topic around that and it meant that he was centre of attention for a good reason ... so he did really well in that because it's what he enjoyed (Amy, Teacher, PRU).

This is a strategy recognised in other literature, where teachers reveal that they take advantage of personal interests (Furtick, 2010) and students with ADHD express a preference for relevant and purposeful content (Partridge, 2009).

Inclusive strategies

Given that the strategies reported by participants in the current study involved making individual adaptations so that the child can access the classroom, these strategies were inclusive rather than involving withdrawal from regular teaching. Some participants in the current study mentioned that they aimed to do the opposite: "My role is to try to keep the child in the lesson" (Hannah, Teaching Assistant, Secondary).

There was further evidence that participants typically took an inclusive approach to teaching students with ADHD, as they discussed the importance of providing academic work that the students could complete: "it's about looking at something and feeling that you [student] can actually do it". Part of the motivation appeared to be that if classwork "is too challenging, they [students] will completely disengage" (Tarquin, Teacher, PRU).

The strategies used by educators working with students with ADHD are inclusive, but are used with a range of students, not just those with ADHD, often leading to an approach tailored to the individual. It is clear that practitioners are not using evidence-based programmes designed for students with ADHD.

Barriers and facilitators

As well as speaking about the strategies they used with their students with ADHD difficulties, practitioners also raised some factors that can either help or hinder the success of these strategies. Participants' narratives revealed that labelling was often a barrier, medication was often a facilitator and that relationships could affect the use of strategies positively or negatively.

Labelling

Practitioners discussed the process of labelling, or the process by which a label like 'ADHD' is applied to a person, as important to managing pupils with ADHD. This label may then lead to stigmatisation from others and changes in behaviour that befits the label (Bailey & Thompson, 2009). Labelling can be helpful, as practitioners often saw a diagnosis as validating problematic behaviour as a medical condition, which assists children and their parents to understand their difficulties and gives further access to support in school. Indeed one practitioner said "I think having that diagnosis can help them access other support" (Maisy, SENCo, Primary). However, participants noted that a diagnosis alone is "Not a wand that can be waved" (Maisy, SENCo, Primary) and more often spoke about how the negative aspects of labelling can affect the classroom. Practitioners gave examples of how the ADHD label can be used as an excuse by students in the classroom:

Sam came in last year when he was what, 9 or 10, said 'it's alright I don't have to do that I've got ADHD' (Kate, Teaching Assistant, Primary).

And this may be encouraged at home:

You do find that with the families ... it's an excuse, then the family come in and 'he's got ADHD so that it explains it all' and it's kinda like no it don't really explain it all there's more to it than just a label (Monica, Teacher, PRU).

Participants saw that the diagnosis removes blame from the child, "almost validates the behaviour and gives them a reason for it" (Paula, Teacher, PRU); placing the responsibility for behaviour

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elsewhere was not seen as entirely helpful. Participants raised concerns about the seeming permanency of the label: “Is it going to affect your life forever” (Jennifer, Headteacher, Primary).

Practitioners did not think that categorising children as having ADHD is always helpful, recognising that there are individual differences amongst their students with ADHD and therefore seeing the problem when they “all get put in that box” (Jemima, Teacher, PRU). Participants also see the “danger of labelling something [ADHD symptoms] that you see in all children at some point” (Rose, Team Leader for Learning Support, Secondary).

Stigma around ADHD has been seen as a barrier to intervention use in previous research (Gwernan-Jones et al., 2016). In the current study, some practitioners “don’t think it’s nice to have that [ADHD] label” (Bryony, SENCo, PRU) because “so many people are ... stigmatised by these sorts of things” (Tarquin, Teacher, PRU). One participant pointed out that other learning difficulties like dyslexia are more “socially acceptable” (Janet, Teacher, Secondary) than ADHD. Another participant spoke of “the shame” (Bryony, SENCo, PRU) surrounding ADHD and how this can lead students to be reluctant to ask for or accept help.

Medication

While drugs were not mentioned as much as the strategies practitioners implemented in the classroom, participants saw positive impacts of medication that can then allow the more effective use of strategies in the classroom:

When he had his medication it gave him that time for us to be able to talk to him for him to then make a better choice and I think that’s what it was about, it was just giving him that time to then make that choice (Maisy, SENCo, Primary).

However, practitioners raised some issues regarding adverse effects:

Soon as the medication was put on it might as well have been a zombie and it was painful as a teacher because it’s like you’ve taken the personality of that child out (Tammy, Teacher, Primary).

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The mixed views regarding the helpfulness of medication seen here, match the views of parents in Ghosh et al. (2016).

Relationships

Practitioners considered the relationships children with ADHD hold as key to their success in school and therefore social skills and relationships are targeted by practitioners in the classroom. Participants saw developing relationships with students with ADHD as an important part of the teaching role.. Practitioners believe that good relationships in school helps children with ADHD be successful and can increase their self-esteem:

Just really going like 'oh that's fantastic' and you could see them fill with pride and then they want to do more for you and they want to try (Janet, Teacher, Secondary).

Practitioners spoke about needing to use empathy in order to “Try to understand it from their [students with ADHD] point of view” (Wilbur, Teacher, Primary).

Practitioners' views here imply that their relationships with students with ADHD are fundamental and a component of any successful strategy in the classroom:

Building a relationship ... we know it's key to trust (Ryan, Pastoral Leader, Primary)
It's very important that they develop that relationship, because it helps them to feel ... normal (Hannah, Teaching Assistant, Secondary).

However, relationships with students with ADHD are often challenging:

My relationship with him [student with ADHD] a few months ago was really really difficult (Louise, Subject Coordinator, PRU).

Practitioners reported the need for understanding and acceptance of the disorder as well as the benefits of acting as an advocate:

It's not a very positive experience of school, so you have to build a relationship which restores some self-esteem in this setting ... I'm an advocate for them so I will go to parents evenings and things and back them up if necessary (Bryony, SENCo, PRU).

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This is important as poor relationships between teachers and students with ADHD have been shown to have a negative effect on intervention experience in literature (Ljusberg 2011).

The relationships students with ADHD hold with their peers were described by practitioners as “rollercoaster relationships” (Ryan, Pastoral Leader, Primary). Practitioners reported using positive peer relationships, “trying to put children together that would be able to work together” (Tarquin, Teacher, PRU).

The importance of social skills is recognised across a number of previous studies where such skills were actively incorporated into interventions and teaching strategies with perceived effectiveness (Moore et al. 2015). In the current study, practitioners mentioned developing social skills so their students with ADHD “learn to interact with all different people” (Hannah, Teaching Assistant, Secondary) and can manage their social interactions.

Discussion

The current study used qualitative data collection and analysis to explore educators' responses to ADHD in the classroom. Findings suggest that the participants used a range of general, inclusive strategies to help children with ADHD cope in school, as opposed to ADHD-specific interventions and withdrawal from classrooms. The strategies described often placed the focus on the deficit skills and needs of individual children with ADHD, meaning there was rarely recognition of how the school context can influence the impairments associated with ADHD or evidence of a response at the class or school level. Practitioners did not mention using recognised intervention packages (for instance daily report cards (Moore et al. 2016b)) with students with ADHD. Instead strategies tended to be used in an ad hoc and flexible manner, which is consistent with reports amongst the existing qualitative literature (Moore et al. 2016a). Given that the goal of educators might be to support children with ADHD in accessing the curriculum and coping with school, rather than treating symptoms per se, these more generic strategies are important tools. However, the lack

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of use and indeed knowledge of evidence-based interventions for ADHD, aside from medication, raises an important implication. Higher levels of awareness about ADHD among educators might support the development of ADHD specific strategies and interventions, and tools such as MindEd (<https://www.minded.org.uk>), are a welcome resource to support teachers who are seeking such information.

Participants provided several factors that help and hinder their ability to manage students with ADHD in school, and it was striking that these functioned as both barriers and facilitators. Labelling, medication and relationships were seen to support children with ADHD in some situations; however, stigmatisation, adverse effects of medication and the rollercoaster relationships with peers can further complicate what is already considered by practitioners to be “complex and challenging” (Bryony, SENCo, PRU). Participants’ description of labelling and stigma indicate that it is the reaction to ADHD rather than use of the label that may cause issues and hinder classroom management. There is therefore a continued need to tackle stigma and negative perceptions about ADHD (Bellanca & Pote, 2013). While participants in this study considered these factors in isolation, it should be noted that these barriers working together can compound the difficulties faced by students with ADHD. For instance, Singh et al. (2013) note the stigmatising link between ADHD diagnosis and drug treatment and Gwernan-Jones et al (2016) discuss the way in which stigma might operate as a barrier to better relationships for children with ADHD. This suggests that a focus on social skills alone from practitioners in the current study may not necessarily improve relationships.

Although to our knowledge this is the first qualitative study of UK educators’ experiences managing students with ADHD, we found many similarities to the experience and attitudes reported in previous studies sampling participants from other countries and educational systems. Previous studies have noted that students with ADHD can be resistant to rewards (Wong, 2004). The view of participants that work needs to be suitably achievable but challenging is seen in other literature

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(Rafalovich, 2004). As for the current study, labelling is not necessarily seen as purely negative in other literature either. Rafalovich (2004) noted that teachers have varied opinions on the effectiveness of labelling, ranging from damaging to the child's self-esteem to a necessary precursor for effective school-based treatment. . Houghton et al.'s (2006) also recognised the importance of the student-teacher relationship, which were seen to be at the heart of effective strategies for students with ADHD.

There are some noticeable differences between the views reported by educators here, compared to other samples. The practitioners in the current study favoured inclusive strategies, in contrast, previous literature suggests that educators believe that withdrawing children with ADHD from their regular classroom to allow for specialised learning is beneficial (e.g. Hillman 2011; Nowacek & Mamlin, 2007). This may reflect policy movements encouraging inclusion for students with special educational needs in the UK (Kennedy, 2015). Participants reported promoting positive peer relationships, whereas teachers in Houghton et al.'s (2006) study expressed little sympathy for experiences of peer rejection faced by students with ADHD. Educators in the current study tended to speak positively about how they manage ADHD in the classroom and did not explicitly report that they lacked knowledge or guidance regarding working with students with ADHD as has been reported (see Ljusberg 2011). Educators noted that medication often enables their strategies, but primary school teachers in Moldavsky et al.'s (2014) study reported typically negative views about medication for ADHD. The majority of the previous research occurred in countries other than the UK and therefore in different educational systems, which may explain some variability in findings compared to the current study.

Strengths of the methods included the inclusion of a variety of schools and practitioner roles. The broad nature of the semi-structured interview schedule meant that the themes reported above were not an artefact of the research question or the questions posed. Limitations of the study include the generalisability of findings; given the study was conducted in a relatively small

geographical area, and that the sample cannot be inferred to be representative of all educational practitioners, indeed there were more primary and special educational practitioners than would be representative of all schools approached. The use of both focus groups and interviews allowed for richer data, as focus groups often contained descriptions of experience from multiple staff, while the individual interviews typically provided more detailed responses. One noticeable difference between the current findings and other papers with different populations appears to be the wide range of strategies used and the perceived success participants have in managing ADHD in the current study. This could be attributed to the volunteer sample, where practitioners with more positive views may have agreed to participate.

This qualitative study has implications for intervention design. It is important that ADHD difficulties are remediated given the relatively high number of children that experience such impairments and the lasting educational deficits these children face (Daley & Birchwood 2010). Educators report using general strategies with their students with ADHD that are not often focused on the core symptoms of the disorder. We therefore recommend that the implementation of evidence-based school-based interventions for ADHD needs further research (Owens et al., 2014; Eiraldi et al., 2012). However, the strategies used by practitioners to target the skill deficits of individual students with ADHD are important to retain alongside interventions focused on ADHD symptoms. Therefore, we perhaps need to consider the development and testing of a range of more flexible intervention components that can be applied as required for the individual in question rather than intervention packages aimed at anyone with the disorder. Given the seeming importance of inclusive strategies and relationships, interventions used in the classroom that involve peers may be more acceptable and hold more perceived effectiveness for educators. This study suggests that factors such as the stigmatisation of ADHD, relationships held by students with ADHD and interaction with any medication need to be carefully considered when classroom strategies are put in place.

Key Messages

- There is limited qualitative research exploring the experiences of educators, particularly within the UK, regarding work with students with ADHD.
- Educators report using a range of inclusive strategies with their students with ADHD that are rarely focused on the improvement of the core symptoms of the disorder or changing the context of the classroom.
- Educators do not report the use of evidence-based interventions and implementation studies need to explore a more flexible approach to align with current practice.
- The educators interviewed recognised that the labelling experienced by children with ADHD, medication use and their relationships can all both help or hinder the success of classroom management.
- School-based strategies are needed that take into account the relationships, other treatments and potential for stigmatisation of children with ADHD.

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